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Georgia APS Emergency Relocation Funds

I. Introduction and Purpose

- A. Victims of adult abuse, neglect or exploitation (A/N/E) are likely to be disabled or frail adults with an accumulation of health, social, economic and environmental problems which impede independent living. Disabled adults and elder persons who are victims of A/N/E exhibit problems and circumstances which are unique and disparate and which demand differential responses and interventions.

This fund source is designed to be a resource to aid victims of A/N/E in Georgia. To be eligible for the APS Emergency Relocation Funds, an elderly or disabled adult must be receiving Adult Protective Services from the Georgia Division of Aging, Adult Protective Services Program and the funds are needed to remedy or prevent abuse, neglect or exploitation.

- B. While an array of medical, housing and personal services may be available in the community, often victims often face unique barriers which prevent access to available relocation related resources. Adult victims may have difficulty accessing services because they lack personal funds or because they have lost the ability to secure resources. Compounding this situation are: gaps in publicly supported services, waiting lists, lack of local services and application or processing delays that threaten the health and safety of clients. In addition, many disabled and elderly victims of domestic violence situations need immediate actions to protect them from further abuse.
- C. Temporary short term or emergency services, as well as relocation of the client are often

measures needed to secure the health and safety of APS clients. This fund source is designed to provide APS Case Managers the necessary support to provide protective services and relocation assistance as appropriate when needed when A/N/E is identified.

- D. Actions taken by the Office of Regulatory Services or situations of serious threat to the well being of PCH (licensed or unlicensed) residents may necessitate temporary or permanent relocation to reduce risk or harm. A resident may need to be relocated to a personal care home, a shelter, motel or other temporary situation, until other arrangements can be made. In addition, there may be a need for basic personal items in order to complete the relocation.

The Division of Aging Services, Adult Protective Services has been designated the “Lead Agency” in Emergency Relocations related to personal care homes. In this role APS is responsible to form and provide leadership to local DHR PCH relocation teams. ERF can be used as a fund source to assist with expenses incurred by clients in the relocation process. An example would be to pay for client medications or to make the initial payment for a personal care home placement associated with a relocation effort.

Facilities subject to licensure will only be reimbursed if they are licensed; homeless shelters and domestic violence shelters are not eligible.

**Emergency Relocation
Plan/Procedures for
Personal Care Homes
Georgia Department of Human
Resources, Division of Aging Services**

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Introduction

These procedures address emergency relocation for residents of Personal Care Homes (PCH)

which are under adverse action initiated by the Office of Regulatory Services (ORS).

The Georgia Department of Human Resources (DHR) is responsible for relocating or assisting

with the relocation of personal care home residents as cited in: O.C. G. A. 31-7; "Rules of the

Department of Human Resources for Personal Care Homes, 290-5-35"; and the Rules of the

Department of Human Resources- Public Health, 290-5-44".

The Commissioner has designated the Division of Family and Children Services (DFCS) as State

Relocation Team Coordinator. For all State Relocation Team members, emergency personal care

home relocation indicates an immediate assignment designation when meetings are called.

There are no financial resources designated to use in the emergency relocation of PCH residents.

All financial arrangements must rely on the resident's own income and resources.

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Glossary

Adverse action: Action against a long term care facility (LTCF) which may involve:

- a. Revocation of license to operate
- b. Injunction against operation of unlicensed home
- c. Invocation of an Emergency Order

Emergency order or order: means a written directive by the Commissioner of DHR prohibiting

additional admissions to an institution, placing a monitor in an institution, or requiring emergency relocation of patients or residents.

Emergency Relocation of Patients or Residents (31-7-2.2): The Commissioner may order the

emergency relocation of residents from an institution subject to licensure when it has been

determined that the residents are subject to imminent and substantial danger. When the Order is

issued, the DHR Commissioner shall provide for:

- a. notice to the resident, his next of kin or guardian, and his physician of the emergency relocation and the reasons therefore;
- b. relocation to the nearest appropriate institution; and

c. other protection designated to ensure the welfare and, when possible, the desires of the resident.

Personal Care Home (PCH): is any dwelling, whether operated for profit or not, which undertakes through its ownership or management to provide or arrange for the provision of housing, food service, and one or more personal services for two or more adults who are not related to the owner or administrator by blood or marriage.

Non-Emergency Relocation Procedure:

_ After one or more visits to the facility, ORS makes a determination to revoke the permit.

_ ORS provides a copy of notices to DFCS.

_ A hearing is held if necessary, and the Administrative Law Judge makes a determination.

_ Move residents; time frame to be established by the Administrative Law Judge.

Facility

may assist with the relocation.

_ If the decision is appealed, the decision is stayed until notice is received from the Administrative Law Judge.

Non-Family Adult: means a resident 18 years of age or older who is not related by blood within

the third degree of consanguinity or by marriage to the person responsible for the management of

the personal care home or to a member of the governing body.

Personal Services: includes but is not limited to, individual assistance with or supervision of self administered

medication, assistance with ambulation and transfers, and essential activities of daily living such as eating, bathing, grooming, dressing, and toileting.

Relocation: Moving of a resident to a licensed personal care home, a licensed health facility, or

other appropriate living setting.

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Agency Summary of Responsibilities*

ORS Long-term care section of ORS initiates adverse action letter to PCH owner and assures due process.

Informs State Relocation Team Coordinator of action and dates.

DFCS Deputy Director of state DFCS office or Designee serves as coordinator of State PCH Relocation Team.

County DFCS Director or Designee serves as coordinator of Local PCH Relocation Team.

DAS Long Term Care Ombudsman insures resident advocacy and advises teams of Residents' Rights.

Community Care Services Program assists with assessment and relocation when Alternative Living Services or Community Care clients are involved.

MH/DD/AD Assists with assessment and relocation of mentally ill/mentally retarded residents.

DPH Assists with assessment and relocation of residents.

* Each agency involved will operate within its legal capabilities and limitation.

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Relocation Team: Persons responsible for personal care home resident(s) relocation.

Resident: means any non family adult receiving personal assistance and residing in a personal care home.

State PCH Relocation Team Members include staff from:

- _ Division of Family and Children Services (DFCS)- is the Coordinator of the State PCH Relocation Team
- _ Division of Mental Health/Developmental Disabilities/Addictive Diseases-Regional Board Executive Director (MH/DD/AD)
- _ Division of Aging Services (DAS)
- _ Division of Public Health (PH)
- _ Office of Regulatory Services (ORS)
- _ Other state level Departments, Divisions, and Offices maybe included, as necessary, depending on the circumstances of the situation.

Local Relocation Team Members include staff from:

- _ County Department of Family and Children Services- is the Coordinator of the local PCH Relocation Team
- _ Regional Mental Health/Developmental Disabilities/Addictive Diseases Services
- _ Long term care ombudsman
- _ District Public Health and County Health Department
- _ Other local agencies/entities may be included, as necessary, depending on circumstances of the situation.

Responsibilities of DFCS- State Office

- _ DFCS Deputy Director or designee is the coordinator of the State PCH Relocation Team.
- _ Receives official notification of adverse action from the Long-term care section of office of Regulatory Services.
- _ Convenes the State Relocation Team and designates a "relocation situation".
- _ Mobilizes resources of all DHR divisions and offices in the relocation effort.
- _ Communicates daily or as needed with State Team members regarding needs, expectations, and decisions impacting the relocation process.
- _ Communicates daily or as needed with County DFCS Director or designee and advises the Local PCH Team Coordinator of needs, expectations, and decisions impacting the relocation process.
- _ Secures a list of licensed personal care homes and adverse action homes from ORS (PCH) unit and transmits the list to the County DFCS.

_ Convenes meetings as needed to exchange information, update State PCH Relocation

Team and make decisions affecting relocation.

_ Facilities process with Team Members to arrange for health assessments and mental health/mental retardation assessments to eligible residents being relocated.

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_ Assures that the necessary relocation actions from each agency occur with attention to timeliness.

_ Facilitates the sharing of information among all agencies/offices involved.

_ Provides technical assistance to Local PCH Relocation Coordinator Distributes copies of relocation reports, forms, and checklists. Monitors status of relocation process.

_ Informs State Relocation Team of outcome of relocation.

Responsibilities of Office of Regulatory Services State Office

_ After one or more visits to a facility where ORS makes a determination that residents are subject to imminent and substantial danger, then ORS makes a preliminary call to DFCS state PCH Relocation Coordinator advising him or her of the situation. With input from DFCS and based on severity and threat of harm to residents, ORS determines the date by which relocation should be accomplished.

_ ORS prepares proposed Emergency Relocation Order and presents it to the Commissioner of DHR. IF DHR Commissioner finds that residents are subject to imminent and substantial danger the Order is signed.

_ ORS formally serves the PCH provider with notice of adverse action and the Emergency Relocation Order.

_ Notifies State PCH Relocation Coordinator of Official adverse actions.

_ Provides the State PCH Relocation Team Coordinator with copies of letters relating to an adverse action. Immediately notifies DFCS and provides a copy of an Emergency Relocation Order. Notifies Team Coordinator of developments which may affect the relocation of residents.

_ Receives and responds to calls and inquires from the media, the public, residents and their families, or state agencies regarding the process of adverse action, and findings regarding care and services in the home.

_ Communicates with the State PCH Relocation Team Coordinator and other Team members, as needed.

_ Provides a list of licensed personal care homes and adverse action home to the DFCS State Team Coordinator.

_ Facilitates access to PCH residents by local team members.

_ Participate as a member of the State Relocation Team.

_ Provides information, known by ORS, to the State Team including: number of residents involved; residents' names, individual characteristics, medical conditions, etc. Uses Relocation Sheet.

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Responsibilities of Mental Health/Developmental Disabilities/Addictive Diseases State Office and/or Regional Board Executive Director

- _ Maintain active memberships representing the Division on the State PCH Relocation Team.
- _ Provide assistance to the State Team by facilitating the assessment and relocation of MH/DD/AD residents in the PCH.
- _ Initiate and maintain contact with local MH/DD/AD staff to coordinate information and provide communication and assistance as needed.
- _ Advocate MH/DD/AD for residents in PCHs.

Responsibilities of Division of Public Health- State Level

- _ Maintain active membership representing the Division of Public Health on the State PCH Relocation Team.
- _ Provide assistance to the State Team by facilitating the assessments and relocation of residents in the PCH.
- _ Initiate and maintain contact with District Public Health Staff to coordinate information and provide communication and assistance as needed.

Responsibilities of Division of Aging Services- State Office

Long Term Care Ombudsman

- _ Maintain active membership representing the Ombudsman Program on the State PCH Relocation Team.
- _ Assist the State Team by facilitating relocation of residents in the PCH.
- _ Initiate and maintain contact with local staff to coordinate information and provide communication and assistance as needed.
- _ State Ombudsman provides assistance to the State Relocation Team in developing and implementing policies and procedures for relocation of residents which will support residents' rights to make informed choices about their care and protect their rights as PCH residents.
- _ Provides communication and technical assistance to local Ombudsman Program regarding the policies and procedures developed by the State PCH Relocation Team and the local Ombudsman's role in the relocation effort.
- _ Communication with other Division of Aging Services staff to access additional resources, such as Community Care Services Program.

Responsibilities of Local PCH Relocation Teams DFCS Coordinator:

- _ Identifies Local PCH Relocation Team members and alternatives; maintains telephone numbers (office/home) where members can be reached.
 - o Team members from:
 - o County DFCS
 - o MH/DD/AD
 - o Long term care ombudsman
 - o Local Public Health Department
- Other parties considered necessary for relocations
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- _ Convenes Local Team meetings to present facts and status of relocation proceedings;

makes team assignments; plans for follow up meetings; determines mode of communication for team members; maintains record of meeting and assignments. Calls meetings as needed.

_ Contact DFCS Field Manager to secure additional manpower or other support, when needed.

_ Keeps State Team Coordinator informed of progress and/or problems daily or as needed;

requests technical assistance from State PCH Relocation Team as needed.

_ Use lists of available licensed PCHs received from the State Team Coordinator for making referral and placements. Provide feedback to state as necessary.

_ Arranges for communication with local Social Security Office to expedite change of address for residents who are relocated.

_ Handles local media releases and interviews.

_ Conducts debriefing meeting within one week after relocation is completed.

_ Completes final disposition report for State Relocation Team Coordinator within two weeks of relocation completion.

Responsibilities of Local PCH Relocation Team members-

It must be noted that individual team members have different roles and must act within their

own capabilities and limitations.

_ Participate in Local Team meetings to review facts and status of adverse action/relocation

proceedings.

_ Respond to assignments of Local PCH Relocation Team Coordinator.

_ Participate in gathering information concerning each individual in the PCH as directed by

the Local Team Coordinator.

_ Participate in gathering information concerning each individual in the PCH as directed by

the Local Team Coordinator.

_ Participate in determining resident preferences, locating other placements, communicating with families and residents, arranging transportation for the move, and moving residents when the resident/family is unable to accomplish this on their own.

_ Complete individual documentation on residents and final report.

_ The following task must be accomplished by the Local Team:

- o Resident assessment
- o Documentation on each resident
- o Identification of alternatives for each resident
- o Transportation of resident and belongings, as needed
- o Satisfactory placement of residents in new living settings
- o Follow-up with each resident and necessary referrals
- o Final report

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Instructions for the Relocation Sheet

The Relocation Sheet is used to document basic information on:

- _ The resident in potential need of relocation;
- _ The resident's family, representatives, and physician;
- _ Health and medication information; and
- _ Status of relocation and needed follow-up.

Information for the Relocation Sheet is initiated by ORS staff (through contact with the PCH

and the residents) and sent to the State DFCS PCH Relocation Team Coordinator in situation

requiring intervention.

Following relocation, Section IV is completed and a copy of the Relocation Sheet is sent to

ORS (in addition to other Divisions needing to provide follow-up).

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Personal Care Home Relocation Sheet

Personal Care

Home _____
Address _____

City _____ State _____ Zip Code _____

Phone _____

Section I Resident Information

Resident's Name _____

DOB _____ Age _____ Gender _____

SS# _____

Medicaid Y_ N_ Number _____

Medicare Y_ N_ Number _____

Income Source(s) and Amount

\$ _____

\$ _____

Current Personal Care Home Monthly Charges

\$ _____

Date Last Paid _____ Refund Due? Y_ N_

Does the Personal Care Home provider participate in any state or federally funded service (e.g., VA, MH/DD/AD, CCSP, and Source)? If so, Specify:

If yes, is the resident a recipient of this publicly funded service? Y_ N_

Section II Family/Responsible Party/Legal Surrogate

Name _____

Relationship _____

Address _____

Phone (s) _____

Legal Guardian Y_ N_ Rep. Payee Y_ N_ Power Of Attorney Y_ N_

Name

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Relationship

Address

Phone(s) _____
Legal Guardian Y_ N_ Rep. Payee Y_ N_ Power Of Attorney Y_ N_

Section III Health

Health Care Power of Attorney

Living Will

Do Not Resuscitate (Allow Natural Death)
Order _____

Doctor / physician

Phone _____
Address

Physical / Mental Health Status Including Diagnosis & Any Functional Limitation:

Mental / Behavioral Condition / Diagnosis / Status:

Medications: Rx Pharmacy

(Medication) (Dosage) (Schedules)

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Section IV Relocation Status

Date of Relocation:

Reason for Relocation:

Substandard Care Court Order

Adverse Action Fire

No License Natural Disaster

Other (Please Specify)

Type of facility resident moved to:

Personal Care Home Family Home

Nursing Facility Hotel / Motel

Boarding Home (No State License Required)

Hospital Admission Other ()

Address: County:

Contact Person: Phone:

Is This A Temporary Relocation? Y_ N_

Relocated By:

Phone #

Comments:

Follow-Up (Date)

APS CCSP

ORS MHDDAD

Ombudsman Other

Comments

**DEPARTMENT OF HUMAN RESOURCES
DIVISION OF PUBLIC HEALTH
NURSING FACILITY RELOCATION
POLICIES AND PROCEDURES
MANUAL OF OPERATION**

January 2007

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INTRODUCTION

These procedures address emergency relocation for residents of nursing facilities which are under adverse action initiated by the federal Centers for Medicare and Medicaid Services (CMS), The Department of Community Health, Division of Medical Assistance (DMA) and/or the Department of Human Resources, Office of Regulatory Services (ORS).

The Georgia Department of Human Resources (DHR) is responsible for relocating or assisting with the relocating of nursing facility residents as cited in O.C.G.A. 31-

8-116 and Rules of the Department of Human Resources Public Health Chapter 290-5-44. The Commissioner has designated the Division of Public Health and the District Health Directors as State and Local Relocation Team Coordinators. For all State Relocation Team Members, nursing facility relocation indicates an immediate reassignment designation when meetings are called.

This procedure outlines the roles and responsibilities of each agency, division, and office involved in the relocation process.

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**RESPONSIBILITIES OF
OFFICE OF REGULATORY SERVICES
NF RELOCATION**

1. Provides the State Relocation Team Coordinator, county DFCS Directors and District

Health Director a copy of the notice of termination letter sent by CMS and ORS to the long term care facility detailing conditions of noncompliance which may lead to adverse action.

2. If such a problem situation continues and or correction by the facility is not satisfactory,
verbally updates the State Relocation Team Coordinator as the likelihood of adverse action increases.
3. Provides a formal briefing for the State Relocation Team Coordinator concerning a decision to initiate adverse action which will result in the need to relocate patients. Provides the coordinator with copies of letters and other documentation relating to the adverse action. Notifies State Relocation Team Coordinator immediately of developments which may affect the need to relocate residents or alter the effective date of decertification.
4. Receives and responds to calls and inquiries from the public, residents and their families, agencies, etc. regarding the process of adverse action, ORS findings regarding care and services in the facility experiencing adverse action, process of recertification to the Medicare/Medicaid programs or other matters related to survey and certification of the facility. Attends at least one resident and family meeting at the facility to describe the adverse action process and findings and to respond to resident and family inquiries.
5. Provides or arranges for periodic, and as needed, on-site monitoring of a facility's care and service if the facility remains open with residents during a period of adverse action.
6. Evaluates a list of facilities with vacant beds provided by DMA to delete names of facilities with pending adverse action so that residents in need of relocation will not be referred to such facilities.

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RESPONSIBILITIES OF DIVISION OF PUBLIC HEALTH NF RELOCATION

A. State Division Office

The Environmental Health/Injury Control Branch Director or Designee serves as the coordinator of the **State Relocation Team**. His duties are as follows:

1. Receives official notification of adverse action.
2. Convenes the **State Relocation Team**. Mobilizes resources of all DHR divisions and offices as appropriate in the relocation effort.
3. Secures a list of facilities certified by Medicaid with vacant beds from DMA, and forwards to ORS for review. Also secures a recent Medicaid patient census list for the relocating facility from DMA. Transmits these lists to the District Health Director.
4. Communicates daily or as needed with District Health Director, ORS, and the DHR Commissioner regarding decertification proceedings. Notifies **State Relocation Team** and the District Health Director verbally and with written communications of any official decisions which may affect the relocation process.

5. Convenes meetings as needed to exchange information, updates **State Relocation Team** and makes decisions affecting relocation as needed.

6. Assures that the necessary relocation actions from each agency occur with attention to timeliness (e.g., communication to nursing facility staff, residents and families, cessation of nursing facility admissions, termination dates).

7. Facilitates the sharing of information among all agencies/offices involved.

8. Provides technical assistance to local relocation coordinator. Distributes copies of relocation reports, forms and checklists. Monitors status of relocation progress.

9. Contacts Division of Aging Services for possible option of offering community care assessments to eligible residents being relocated. Facilitates process with Division of Aging Services Team Representatives.

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10. Determines whether transportation needs have been met for relocation of all residents. If the coordinator determines that residents have unmet needs for transportation beyond those provided through the DCH and/or CMS, the coordinator contacts the DHR Coordinated Transportation Services unit for provision of transportation.

11. Informs **State Relocation Team** of outcome of relocation.

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B. District Office

The District Health Director serves as coordinator of the **Local Relocation Team**. His or her duties are as follows:

1. Identifies Local Relocation Team and alternates; maintains telephone numbers (office and home) where members can be reached. Team membership consists of representatives of the following entities:

County DFCS

Division of Mental Health/Developmental Disabilities/Substance Abuse

Division of Aging Services/Area Agency on Aging/Community Care

Services Program

Division of Aging Services/Adult Protective Services

Community Long Term Care Ombudsman

Local Public Health Staff

Other parties considered necessary for efficient and effective relocation

2. Convenes weekly team meetings (or as needed) to present facts and status of decertification or relocation proceedings; makes team assignments; determines mode of communication to team members; maintains record of meetings and assignments.

3. Contacts administrator of nursing facility to arrange for the relocation team to validate patient roster by on-site assessment of each individual by the Division of Aging Services, CCSP assessment team. Patient information roster to include: Residents' name, sex, room number, level of care, payment source (i.e. Medicare, Medicaid, private pay, Veteran's Administration, or other), preliminary assessment of patient's mental and physical condition, mode of transportation for move (ambulance/non emergency, name, address, and phone number of local guardian, responsible person or family member, if any, to contact regarding relocation).

4. Keeps State Relocation Team Coordinator informed of progress and/or problems by contacting 2-3 times per week; requests technical assistance from State Relocation Team as needed.
5. Validates list of available nursing facility beds with facility administrator. Informs team of vacant beds and location. Arranges for relocation of residents choosing to move. If vacant beds availability becomes a problem, notifies State Coordinator immediately.
6. Assures Ombudsman contact for residents needing assistance.
7. Arranges for resident and family meeting to communicate with residents and families and other means of communication as needed to assure accurate information. Coordinates resident and family meeting with local team members and Office of Regulatory Services. Contacts state DFCS to give meeting date for inclusion of notice to residents and families.
8. Secures completed or updated level of care determinations necessary for resident relocation. Assures physician's signature as needed for ambulance transportation.
9. Coordinates with the local Division of Aging Services, Community Care Services Program (CCSP) for assessment of residents needing relocation.
10. Handles local media releases and interviews.
11. Conducts debriefing meeting within one week after relocation is completed.
12. Completes final disposition report for State Relocation Team Coordinator within two weeks of relocation completion.

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**RESPONSIBILITIES OF
DIVISION OF MEDICAL ASSISTANCE
DEPARTMENT OF COMMUNITY HEALTH
NF RELOCATION**

1. Obtains a bed registry and most recent Medicaid patient census and forwards to State Relocation Team Coordinator.
2. Generates a Medicaid program termination letter to the nursing facility administrator.
3. Gives the Division of Family and Children Services authorization for mailing recipient notification letters. Timing of the authorization should allow for as close as feasibly possible to 30 day notice for residents regarding eligibility.
4. Suspends nursing facility admissions and notifies State Relocation Coordinator.
5. Assures correct termination date for the State Relocation Coordinator.
6. Monitors the relocation of Medicaid residents for payment purposes.
7. If nursing facility bed availability becomes a problem during relocation, assists with responsibility for alternative placements (e.g., hospital or home with Medicaid waiver services such as CCSP).
8. Approves the updating of the level of care of the patient for relocation as needed if the patient is moved to another nursing facility or other Medicaid program to insure there is no break in payment to the admitting provider.
9. Upon notification by the nursing facility or the local relocation team, identifies the ambulance provider which will transport Medicaid eligible residents to other facilities.

Reimburses the ambulance provider for transportation related to the relocation.

10. Coordinates the transporting of Medicaid eligible residents identified as having transportation needs. All Medicaid-eligible residents in need of transportation may receive ambulance transport to another placement.

11. Upon the request of the local relocation team, provides a list of non-emergency transportation providers who may choose to provide stretcher transport for non-Medicaid

eligible residents on a fee-for-service basis.

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RESPONSIBILITIES OF DIVISION OF FAMILY AND CHILDREN SERVICES NF RELOCATION

A. State Medicaid Unit Responsibilities:

1. Receives a copy of the official notification to the nursing facility of intended action and effective date from the DPH State Relocation Team Coordinator.
2. Receives from DMA a listing of the Medicaid residents at the nursing facility.
3. Contacts the county DFCS where the nursing facility is located. Requests the county DFCS to send a list of the Medicaid residents and patient's responsible relative to the State Medicaid Unit.
4. Upon receipt of text and authorization from DMA, prepares notification letters to be sent to residents and responsible relative, giving thirty days notification and local DFCS telephone number for questions pertaining to Medicaid eligibility.
5. Prepares address labels and makes five copies of each letter, on each for the responsible party (if any), the state DFCS Medicaid Unit, county DFCS, DMA, and the nursing facility administrator.
6. Upon authorization from DMA, mails the notification letters via first class mail.

B. Joint Responsibilities of State Medicaid Unit:

1. Provides information/technical assistance as requested by State Relocation Team Coordinator (DPH).
2. Provides service policy clarifications and information to county DFCS staff, State and Local Team Coordinators.
3. Sends information to social service county staff regarding nursing facilities involved in adverse action.
4. Responds to requests from county/regional DFCS staff for information and clarification on policy as it relates to nursing facility relocations.

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C. Local DFCS Responsibilities:

1. Responds to assignments of Local Relocation Team Coordinator (District Health Director) through the DFCS Field Coordinators or County Director.
2. Completes the list of Medicaid residents in the nursing facility, completes the list of the Medicaid residents' responsible parties, and forwards to the State Medicaid Unit. During this process, the county resident lists are reconciled with the information obtained during the on-site assessment at the local level, and the local county DFCS office is identified to be named in the notification letter as contact to answer questions which relate to Medicaid eligibility.
3. Participates on the local relocation team for on-site assessment of each individual

in the nursing facility.

4. Participates with team representative to facilitate the actual move of residents to new facilities.

5. In cases of decertification, provides DMA Form 59 for those residents who elect to stay at the nursing facility as DMA can terminate Medicaid vendor payments to the nursing facility and terminate eligibility as appropriate.

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RESPONSIBILITIES OF DIVISION OF AGING SERVICES NF RELOCATION

A. State Ombudsman Program

1. Provides assistance to the State Relocation Team in developing and implementing policies and procedures for relocation of residents which will support residents' rights to make informed choices about their care and protect their rights as citizens and as nursing facility residents under the state and federal regulations.

2. Provides technical assistance to Community Ombudsman Programs regarding the policies and procedures developed by the State Relocation Team and the Community Ombudsman Program's role in the relocation effort.

3. Shares information with State Relocation Team about community resources available for residents.

B. Local Ombudsman Program

1. Insures that individual resident's rights are protected throughout the relocation process and provides assistance to residents regarding problems or complaints which they may have throughout the relocation process.

2. Provides information upon request to residents and/or family members which may assist them in making choices about resident's care and placement.

3. Shares information with Local Relocation Team about community resources available for residents.

C. Community Care Services Program

1. Coordinates with State Relocation Coordinator on availability of Community Care Services Program for eligible residents being relocated.

2. Provides assistance, upon request, to local agencies involved in screening and placement of individual residents.

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D. DAS/Adult Protective Services Responsibilities

1. State Office APS staff serves on the State Relocation Team and communicates needs to Regional APS staff. Regional (local) APS staff responds to assignments of Local Relocation Team Coordinator (District Health Director) through the DAS/APS District Manager or Regional Supervisor.

2. Local APS staff participates on the Local Relocation Team for on-site assessment of residents in the nursing facility.

3. Local APS staff talks with residents and responsible parties about placement options along with other Relocation Team members. DAS/APS relocates residents for whom Department of Human Resources is Guardian of Person.

4. If resident is not capable of making a decision and no family/friends are available to assist, Adult Protective Services staff tries to locate relatives.

5. When no relatives can be found and the resident is not capable of making a decision, Adult Protective Services staff considers the specific factors and emergency nature of the situation and either recommends that the facility petition the Probate Court for a Temporary Placement Order or DAS/APS where indicated petitions for a guardianship hearing in order to have guardian named.

6. DAS/APS staff participates with team representatives to facilitate the actual move of residents to new facilities.

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**RESPONSIBILITIES OF
DIVISION OF MENTAL HEALTH
DEVELOPMENTAL DISABILITIES
& ADDICTIVE DISEASES
NF RELOCATION**

A. State MH/DD/AD:

1. Provides assistance to the State Relocation Team by facilitating the evaluation and relocation of MH/DD/AD residents in the nursing facility.
2. Maintains contact with District/local MH/DD/AD to coordinate information and lend assistance as needed.
3. Advocates for MH/DD/AD residents in nursing facilities.

B. Local MH/DD/AD:

1. Provides evaluation for MH/DD residents as needed.
2. Assists in seeking resources for these residents.
3. Facilitates relocation process at local level.
4. Participates in local relocation team

MA Sexual Assault Team

Scope of Services Sexual Abuse Training & Consultation

The Sexual Abuse Consultation Group provides identified sexual abuse consultants with enhanced skills and guidance when addressing elder sexual abuse cases. These consultants and other identified individuals will provide guidance and assistance to the Protective Services network regarding elder sexual abuse cases. This contract allows for these individuals to have enhanced clinical guidance and training. Components of the course include: 1) case reviews during quarterly meetings; 2) enhanced clinical consultation during quarterly meetings; 3) additional training on issues and topics related to elder sexual abuse, to be conducted at quarterly meetings; 4) consultation on elder sexual abuse cases at other times throughout the contract period; and, 5) review of case write-ups completed by consultants. The group will meet four (4) times per year.

Other consultation and guidance will be conducted at an hourly rate. The components of each day will focus on strengthening evaluative and clinical skills for those participating, and aiding them in assisting the Protective Services network with elder sexual abuse cases.

The goal is to provide identified elder sexual abuse consultants with enhanced skills and guidance when addressing elder sexual abuse cases. Curriculum development and structuring of the group must be consistent with the primary goals of the course, including:

- a) Increase participants' ability to provide comprehensive clinical guidance on sexual abuse cases;
- b) Improve participants' comfort with peer consultation;
- c) Increase participants' confidence in their ability to form well reasoned and clinically appropriate responses to sexual abuse situations; and
- d) Increase participants' knowledge of additional topics and issues related to elder sexual abuse.

MA Disabled Persons Protection Commission (DPPC)

(Documents are available in PDF form only.)

The following MA DPPC documents will be emailed in separate attachments along with Appendix -2.

DPPC Risk Form

Oversight 301

Investigation 111

Intake 203, 202, and 201

New Mexico

INTERGOVERNMENTAL AGREEMENT

Between New Mexico Department of Health, And Aging and Long-Term Services Department,

This Agreement entered into between New Mexico Department of Health, Division of Health Improvement (DOH, DHI) and Aging and Long-Term Services Department, Adult Protective Services Division (ALTSD, APS).

Article I: Purpose

The purpose of this Agreement ("Agreement") is to clarify the respective roles and responsibilities of the Aging and Long-Term Services Department (ALTSD) and the Department of Health (DOH) pursuant to NMSA 1978, Sections 27-7-1 through 27-7-31, Adult Protective Services Act (the APS Act), and NMSA 1978, Sections 24-1-5 L., 24-1-5 B., 24-1-5.2, 24-1-31., L., O. and V. of the Public Health Act; NMSA 1978, Section 9-7-7 and NMAC 7.1.13 *et seq.* for investigating allegations of abuse, neglect and exploitation of adults in health care facilities.

WHEREAS, the Aging & Long-Term Services Department's and the New Mexico Department of Health have an interest in complaints and referrals of abuse, neglect, and exploitation of adults residing in licensed health care facilities in accordance with the above referenced statutes;

WHEREAS, DOH, has a statutory obligation to promptly investigate complaints occurring at licensed health facilities, and take appropriate action on its investigation. If the complaint is substantiated, DOH will make the necessary referral! notification to ALTSD,APS and otherwise work cooperatively to ensure the health, safety and rights of individuals in licensed health facilities;

WHEREAS, ALTSD, has a statutory obligation to investigate allegations of abuse, neglect, or exploitation of vulnerable adults and to work cooperatively with state agencies, including DOH to ensure the health, safety and rights of individuals in health facilities;

WHEREAS, it is in the best interests of ALTSD, DOH and the public they serve to have the issues of coverage of such investigations properly addressed;

WHEREAS, it is important for ALTSD and DOH to try to work cooperatively to resolve issues of mutual concern regarding response to complaints while at the same time meeting their specific and separate statutory obligations and duties;

WHEREAS, DOH and ALTSD will share all referral and investigative information, reports and findings in accordance with the Joint Protocol established pursuant to NMSA 1978 24-1-5-L.(14) in order to effectively implement this Agreement; [Joint Protocol is attached as Exhibit A to this Agreement]

WHEREAS, in the spirit of coordination and cooperation and in an effort to prevent duplication of investigations while at the same time complying with the appropriate and respective statutory authorities, the Parties agree as follows:

Article II Authority. In accordance with NMSA 1978, Section 24-1-5 L, DOH shall promptly investigate complaints it receives occurring at a licensed health facility, take appropriate action if the complaint is substantiated, coordinate with other appropriate state agencies pursuant to the Joint Protocol, and make the necessary referrals/ notifications to ALTSD;

In accordance with NMSA 1978, Section 27-7-30 A. every person has an obligation to immediately report abuse, neglect, and exploitation of incapacitated adults to ALTSD. ALTSD is required by law (NMSA 1978, Section 27-7-19 A. (3).) to conduct an investigation to determine if a report or referral of abuse, neglect, or exploitation is substantiated. ALTSD shall further coordinate with other state agencies to provide for an adult protective services system (NMSA 1978 Section 27-7-17 B (3).).

ALTSD will determine if further investigation is warranted upon review of the DOH investigation and report in accordance with the following provisions.

Article III: Responsibility of Parties

It is agreed that due to the nature of DOH and ALTSD respective statutory authorities that DOH is generally the initial responder to referrals of allegations of abuse, neglect, or exploitation in all licensed facilities and homes; including, nursing facilities, specifically skilled nursing facilities (SNFs), intermediate care facilities (NFs and ICFMR's), and licensed assisted living facilities when the alleged perpetrator is **under** the direction of the facility (i.e. a facility employee).

It is also agreed that due to the nature of ALTSD' s statutory authority to offer protective services that ALTSD is generally the initial responder to complaints in licensed facilities when the alleged perpetrator in **not under** the direction of the facility (i.e. a member of the family or community).

It is agreed that at the time a complaint is received that both parties to this Agreement will immediately cross report and share information and respond in a manner consistent with their statutory obligations. Additionally, if during an investigation information becomes available that would necessitate the involvement of the secondary responder agency such information will be shared immediately with such agency.

It is agreed that ALTSD will investigate complaints in unlicensed facilities and homes.

Article IV: Information Sharing

When DHI receives a report of abuse, neglect or exploitation involving a health care facility, DHI shall immediately send a copy of the complaint! referral to APS. Additionally, DHI will conduct an investigation of such health care facility and determine if the complaint should be substantiated for abuse, neglect or exploitation. If DHI substantiates abuse, neglect or exploitation it will take appropriate action in response and further forward such report and findings to ALTSD for their use and review in fulfilling their statutory obligations of investigation.

When APS receives a report of abuse, neglect, or exploitation involving a licensed health care facility, APS shall immediately send a copy of that written referral to DH!.

Article V: Special Procedures

There may be other circumstances under which APS staff may be called upon to make a OneTime-Only (OTO) resident safety check at a licensed facility upon the request of the DID.

Article VI: Confidentiality

The Parties to the Agreement shall comply with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its applicable regulations and all other State and Federal rules and laws protecting the confidentiality of information.

Article VII: Liability

As between the parties, each party will be responsible for claims or damages arising from personal injury or damage to persons or tangible property to the extent they result from negligence of its employees, subject in all cases to the immunities and limitations of the New Mexico Tort Claims Act, Section 41-4-1, et seq., NMSA 1978, as amended.

Article VIII: Termination of Agreement

This Agreement may be terminated by either of the parties hereto upon written notice delivered to the other party at least thirty (30) days prior to the intended date of termination.

Article IX: Term of Agreement:

This MOA is effective upon execution by the parties and shall remain in effect until otherwise terminated or modified. This MOA may be terminated at any time by mutual agreement of the parties, or may be terminated unilaterally by any party by providing thirty (30) days written notice.

Article X: Modification to Be **In Writing**: Modification to this MOA may only be made in writing, signed by all of the parties.

Article XI: Sole Agreement:

This MOA supplements all previous negotiations and discussions between the parties concerning the subject matter discussed herein.

Article XII: Severability:

If any provisions of this MOA shall be held void or invalid, the remaining provisions shall nevertheless be valid, effective, and binding.

North Carolina

State survey summary results of NC Adult Protective Services staff and Home Community Based Services Providers is in PDF form only. They will be emailed in separate attachments along with Appendix 2.

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